STATE OF MICHIGAN

COURT OF APPEALS

PEOPLE OF THE STATE OF MICHIGAN, Plaintiff-Appellee,	UNPUBLISHED April 1, 2014
v DR. PETER NWOKE, Defendant-Appellant.	No. 311242 Ingham Circuit Court LC No. 11-000537-FH

PEOPLE OF THE STATE OF MICHIGAN, Plaintiff-Appellee,	
v DIVINE MEDICAL SERVICES, Defendant-Appellant.	No. 311462 Ingham Circuit Court LC No. 11-000529-FH

Before: BOONSTRA, P.J., and CAVANAGH and FITZGERALD, JJ.

PER CURIAM.

The trial court convicted defendants[1] of three counts of Medicaid fraud, MCL 400.607(1),[2] and sentenced defendants to pay restitution, fines, and costs.[3] Defendants appeal as of right in these consolidated cases. We affirm.

Defendants argue that the trial court erred by denying their motion for a directed verdict of acquittal with regard to the three charges of Medicaid fraud for which they were convicted. In

[1] Defendant Peter Nwoke, M.D., worked at defendant Divine Medical Services.

[2] Defendants' convictions resulted from the billing codes regarding the complexity of visits submitted on the billing forms for home visits to patient TD on December 28, 2007, and to patient DG on December 28, 2007, and February 27, 2008.

[3] The court dismissed 16 counts of fraud on defendants' directed verdict motion.

reviewing the denial of a motion for a directed verdict of acquittal, this Court reviews the evidence in a light most favorable to the prosecution in order to determine whether a rational trier of fact could have found that the essential elements of the crime were proved beyond a reasonable doubt. *People v Gillis*, 474 Mich 105, 113; 712 NW2d 419 (2006). Because of the difficulties inherent in proving a state of mind, minimal circumstantial evidence will suffice to establish the defendant's knowledge. *People v Kanaan*, 278 Mich App 594, 621-622; 751 NW2d 57 (2008). Reasonable inferences arising from circumstantial evidence "can constitute satisfactory proof of the elements of the crime." *Id*. at 619.

Defendants were convicted of three counts of violating the Medicaid False Claim Act, MCL 400.601, *et seq.*, for filing claims that did not reflect the level of service provided to patients during medical home visits. The CPT (common procedural terminology) code of 99350 billed by defendants for the home visits at issue reflected a comprehensive service home visit. However, the nurse practitioner who made the home visits at issue coded the visits as 99348 or 99349, reflecting merely detailed or expanded visits.

The elements of Medicaid fraud in violation of MCL 400.607(1) are: (1) the existence of a claim, (2) that the accused makes, presents, or causes to be made or presented to the state or its agent, (3) the claim is made under the Social Welfare Act, 1939 PA 280, MCL 400.1 *et seq.*, (4) the claim is false, fictitious, or fraudulent, and (5) the accused knows the claim is false, fictitious, or fraudulent. *Kanaan*, 278 Mich App at 619. MCL 400.602(f) formerly defined knowing as follows:

> [T]hat a person is in possession of facts under which he or she is aware or should be aware of the nature of his or her conduct and that his or her conduct is substantially certain to cause the payment of a medicaid benefit. Knowing or knowingly does not include conduct which is an error or mistake unless the person's course of conduct indicates a systematic or persistent tendency to cause inaccuracies to be present.[4]

Knowledge of a false claim can be inferred from the defendant's actions. *People v Perez-DeLeon*, 224 Mich App 43, 48; 568 NW2d 324 (1997). Fraudulent Medicaid claims include billings for services not performed. *People v Orzame*, 224 Mich App 551, 562; 570 NW2d 118 (1997).

Defendants argue that defendant Nwoke could not have known that the claims were false because the nature of coding patients' home visits is subjective among medical providers. Defendants assert that plaintiff's expert, Catherine Reid, M.D., testified with regard to how she would code a visit, rather than how a reasonable physician coded services. Defendants further assert that their expert, Marvel Hammer, R.N., testified that nurse practitioners working under a

[4] MCL 400.602(f) was amended by 2008 PA 421, effective January 6, 2009. The version that was in effect at the time of the offenses is controlling. *People v Muniz*, 259 Mich App 176, 19; 675 NW2d 597 (2003).

physician routinely undercode interventions, and that a variance of one level of severity could be considered reasonable.

However, both experts agreed that the two visits in question with patient DG should have been coded as detailed visits of moderate complexity, code 99349. Both experts also agreed that the December 28, 2007 home visit with patient TD should have been coded as a 99349 visit. Expert opinion may pertain to the ultimate issue decided in the case. MRE 704.

Reid testified that CPT codes standardize medical procedures for billing purposes by assigning universally recognized appropriate codes to describe medical interventions. Reid described the requirements for each category of coding home visits. Hammer also described the requirements for each level with precision, including reciting the American Medical Associations's CPT guidelines. Thus, the medical literature provides detailed and objective guidance on how to assess levels of complexity regarding assessing patients during home visits, and the evidence demonstrated that the experts who testified were able to arrive at an opinion regarding which specific code applied to defendants' billings. In the three instances at issue, both experts agreed that overbilling occurred. Although some subjectivity is inherent, these guidelines, as well as training and experience, provide a reasonable standard for determining that a healthcare provider has submitted a knowingly false or fraudulent claim for "payment of a medicaid benefit."

When viewed in a light favoring plaintiff, the evidence demonstrated that defendants knew or should have known that the billing statements were falsely submitted. The trial court accepted expert testimony that the 99350 level of home visit was false for the three visits at issue.[5] In a bench trial, this Court will defer to the trial court to determine the credibility of witnesses and the weight of the evidence. *Kanaan*, 278 Mich App at 619. Moreover, the evidence indicated that defendants were aware of the level of service provided, as reflected in medical records and corroborated by expert testimony. Defendant Nwoke told the supervisor of the Medicaid fraud investigation team that he reviewed all billing forms and delivered them to Diversified Medical Billing every week or two. Defendant Nwoke said that he would co-sign any tests or charts completed by the assistants under his supervision. There was also evidence that the billing codes were changed from those marked by the nurse practitioner who made the home visits before the billing forms were submitted for payment. The nurse practitioner stated that she did not mark the 99350 code that was on the billing forms that were ultimately submitted to the biller.

[5] False means "wholly or partially untrue or deceptive." MCL 400.602(d). Deceptive was formerly defined as "making a claim or causing a claim to be made under the social welfare act, Act No. 280 of the Public Acts of 1939, which contains a statement of fact or which fails to reveal a material fact, which statement or failure leads the department to believe the represented or suggested state of affair to be other than it actually is." MCL 400.602(c). MCL 400.602(c) was amended by 2008 PA 421, effective January 6, 2009. The version that was in effect at the time of the offenses is controlling. *Muniz*, 259 Mich App at 179.

Defendants also argue that they did not have the required knowledge that the claims were substantially certain to cause payment of a benefit. See *Perez-DeLeon*, 224 Mich App at 49. Defendants contend that Medicaid procedures allow Medicaid to pay an insured's Medicare deductible and co-pay until the Medicaid maximum amount is reached. It is true that defendants' biller testified that she does not expect payment from Medicaid for patients that have both Medicare and Medicaid, such as the patients at issue here, because Medicare is billed as the primary insurance and reimburses higher than the maximum Medicaid rate. Also, she stated that she did not know the amount of deductibles for insurances or the rates of reimbursement.

However, where a physician possesses a Medicaid policy, procedures, and coding manual, that physician is expected to have knowledge of the requirements and to abide by them. *Orzame*, 224 Mich App at 560. It is a reasonable inference from the evidence that given this documentation, submitting a claim identical to claims that had previously been paid would create a substantial certainty of payment. Thus, viewing the evidence in a light favoring plaintiff, the trial court did not err in finding that defendants could be found beyond a reasonable doubt to have a substantial certainty of payment. *People v Tennyson*, 487 Mich 730, 735; 790 NW2d 354 (2010).

Defendants argue that the element of submitting a claim to Medicaid was not met because the claims were submitted to Medicare. Their biller testified that she entered the billings she received into her billing software that created electronic files for submission. She said that the files were submitted to a clearinghouse which would send them to the appropriate primary insurance carrier. The clearinghouse crossover mechanism sent the claim to the secondary insurance. Therefore, the evidence indicated that defendants caused a claim to be made to Medicaid, in accordance with MCL 400.607(1), by sending the claim to their biller who entered it into a clearinghouse for distribution to all appropriate insurance carriers.

Defendants also argue that the conviction for Medicaid fraud should only pertain to defendant Divine Medical Services, and not to defendant Nwoke. Defendants assert that the false invoices contain only the stamp of defendant Divine Medical Services and not the signature of defendant Nwoke. Additionally, the stamp affixed to the billing form created a presumption, which was not rebutted, that defendant Divine Medical Services made the Medicaid claim. See MCL 400.608(2).[6]

However, the presumption that defendant Divine Medical Services made a Medicaid claim does not exclude defendant Nwoke from having made claims. On the contrary, substantial evidence indicated that defendant Nwoke made the claims to Medicaid. Defendant Nwoke told the state's investigator that he reviewed and signed all charts and that he reviewed all billing

[6] The statute provides:

> It shall be a rebuttable presumption that a person knowingly made a claim for a medicaid benefit if the person's actual, facsimile, stamped, typewritten, or similar signature is used on the form required for the making of a claim for a medicaid benefit.

forms and routinely delivered them to the biller. The evidence indicated that defendant Divine Medical Services' employees left the billing sheets for defendant Nwoke to review and sign. The biller testified that she had worked with defendant Nwoke since 2006, including in 2007 and 2008, and received mail from him containing the billings. Defendants' argument is without merit.

Affirmed.

/s/ Mark T. Boonstra
/s/ Mark J. Cavanagh
/s/ E. Thomas Fitzgerald